Human Behavior Course
2004

Reactions to Stress & Trauma

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HUMAN BEHAVIOR COURSE 2004
REACTIONS TO STRESS & TRAUMA - SLIDES

LEARNING OBJECTIVES AND STUDY QUESTIONS FOR DISCUSSION.

1. **Know the meaning of the terms and concepts listed in slide one and two below.**
2. **What is the difference between dissociation and psychosis?**
3. **Is it true that PTSD is a "normal response to an abnormal event?" Why or why not?**
4. **Some have suggested PTSD and ASD are dissociative disorders rather than anxiety disorders. How are these disorders like an dissociative disorder? How are they like an anxiety disorder?**
5. **Name the different trauma/stress disorders and list whether they are very common (point prevalence > 5%), common (1-5%) or uncommon (<1%) in the general population.**
6. **Know whether each trauma/stress disorder is more common in men, more common in women, or occurs in a similar proportion of men and women.**
7. **What are the diagnostic features of post-traumatic stress disorder (PTSD)?**
8. **What are the diagnostic features of acute stress disorder (ASD)?**
9. **What are the diagnostic features of dissociative amnesia?**
10. **What are the diagnostic features of dissociative fugue? Contrast dissociative fugue with dissociative amnesia.**
11. **What are the diagnostic features of depersonalization disorder?**
12. **What are the diagnostic features of dissociative identity disorder?**
13. **What are the diagnostic features of adjustment disorder? How is the stressor in this disorder different or the same as the one in PTSD and ASD?**
14. **Describe what is known about the psychosocial pathogenesis of dissociation and the various dissociative disorders.**
15. **Describe what is known about the neurobiological mechanisms of dissociation and the various dissociative disorders.**
16. **What general type of psychotherapy works best for ASD? For PTSD? For dissociative disorders? Name some of the techniques used and give an example of how each might be used to treat ASD, PTSD, and the different dissociative disorders.**
17. **What medications may be used to treat PTSD? ASD? The different dissociative disorders?**

Slide 1

Reactions to Stress & Trauma – Terms & Concepts

- adjustment disorder
- post-traumatic stress disorder
- acute stress disorder
- dissociative disorder
- dissociative identity disorder
- dissociative fugue
- dissociative amnesia
- depersonalization disorder
- dissociation
- dissociation as defense
- dissociation as conversion
- integration
- "alter"
- isolation
- countersuggestion
- depersonalization
- amnesia
- hypnosis
- hypnotic state
- absorption
- suggestibility
- hypnotizability
- narrative truth
- historical truth
- declarative (explicit) memory
- nondeclarative (implicit) memory
- semantic memory
- episodic memory
- medial temporal lobe circuit
- basal ganglia-frontal lobe circuit
- amnestic syndrome
- Ganser syndrome
- personality state
- multiple personality disorder
- true dissociative identity disorder
- iatrogenic dissociative identity disorder
- malingered dissociative identity disorder

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Slide 2

Reactions to Stress & Trauma – Terms & Concepts

- irritable heart
- soldier's heart
- Da Costa's syndrome
- shell shock
- disordered action of the heart
- concentration camp syndrome
- flashback
- traumatic event criterion ("criterion A stressor")
- reexperiencing criteria
- emotional numbing & avoidance criteria
- autonomic hyperactivity & arousal criteria
- delayed PTSD
- compensation & reactivation
- limbic kindling
- hippocampus
- endorphin release
- learned helplessness
- intrusive memories
- nightmares
- eye movement desensitization & reprocessing (EMDR)
- selective serotonin reuptake inhibitors
- tricyclic antidepressants
- lithium
- carbamazepine
- benzodiazepines

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Slide 3

Stress and Trauma

- Stressful Events
  - May be “good” or “bad” (marriage, divorce, new home, loss of home, etc.)
  - Single brief event or ongoing or multiple repeated events.
  - Cause “stress”
- Traumatic Events
  - Treat or perceived threat to life or limb
  - Threat or perceived threat to life or limb of a loved one
  - Handling of dead bodies, seeing others hurt or killed, etc.

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DSM-IV Disorders

- Adjustment Disorder
- Acute Stress Disorder
- Posttraumatic Stress Disorder
- Dissociative Disorders

Slide 5

Adjustment Disorder

- Emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)
- Clinically significant: either by 1) marked distress in excess of what would be expected, or 2) significant impairment in social or occupational (academic) function
- Symptoms not do to another Axis I or II disorder
- Not bereavement
- When stressor(s) stopped symptoms stop within 6 months.

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Adjustment Disorder qualifiers

- Acute: less than 6 months
- Chronic: 6 or more months
- With Depressed Mood
- With Anxiety
- With Mixed Anxiety and Depressed Mood
- With Disturbance of Conduct
- With Mixed disturbance of Emotions and Conduct
- Unspecified

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NOTE: the symptoms of Adjustment Disorder may persist for a prolonged period (i.e.,longer than 6 months) if they occur in response to a chronic stressor (e.g., a chronic, disabling general medical condition) or to a stressor that has enduring consequences (e.g., the financial and emotional difficulties resulting from a divorce).

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Stressors leading to Adjustment Disorders may be:

Single events (e.g., Termination of a romantic relationship),

Multiple independent events (e.g., Marked business difficulties and marital problems),

Recurrent (e.g., Associated with seasonal business crises), or

Continuous (e.g., Living in a crime-ridden neighborhood or with an abusive spouse/parent).

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Differential Dx: Adjustment Disorder

- Personality disorders exacerbated by stress
- Axis I Not Otherwise Specified disorders (e.g., anxiety disorder NOS)
- PTSD and Acute Stress Disorder
- Bereavement
- Non-pathological reactions to stress
- Psychological factors affecting a general medical condition
- Psychological condition resulting from a general medical condition
- Brief psychotic disorder

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Treatment of Adjustment Disorder

- Lack of randomized controlled Rx studies
- Provide practical assistance
- Rational pharmacotherapy
- Reduce the stress load – e.g.
  - Facilitate social supports
  - Minimize stigmatization
  - Psychotherapy and support
  - Education and reassurance
- Protect from second injury. Prevent complications and additional stressors

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DSM-IV Disorders

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Acute Stress Disorder

(An anxiety disorder)

- Event:
  - Actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - Person responded with intense fear, helplessness or horror (disorganization or agitation in kids)
- Symptoms:
  - At least **3 Dissociative** symptoms
  - At least **1 Reexperiencing** symptom
  - At least **1 Avoidance** symptom
  - At least **1 Hyperarousal** symptom
- Distress or impairment
- Duration at least 2 days but less than 4 weeks
- Not due to other things

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Dissociative Symptoms

- Sense of numbing, detachment or absence of emotional responsiveness
- Reduced awareness of surroundings
- Derealization
- Depersonalization
- Dissociative amnesia (can't recall important parts of traumatic event)

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Reexperiencing Symptoms

- Recurrent and intrusive distressing recollections, images, thoughts, perceptions (repetitive play in kids)
- Distressing dreams of the event (or more vague bad dreams in kids)
- Recurrence experiences: flashbacks, a sense of re-living the event, illusions, hallucinations (specific reenactment in kids)
- Distress on exposure to internal or external reminders of event
- Physiological reactivity to internal or external cues

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Avoidance Symptoms

- Avoiding thoughts, feelings or conversations associated with the event
- Avoiding activities, people, places associated with the event
- Inability to recall an important part of the event
- Decreased interest or participation in activities
- Feelings of detachment or estrangement from others
- Restricted range of affect
- Sense of foreshortened future

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Hyperarousal Symptoms

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

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Acute Stress Disorder

(Course of illness)

- 20 to 80% immediately following trauma of auto accident
- One half may progress to PTSD at one month
- One half of those still meet criterion at 6 months
- One half of those spontaneously recover by 1 year
- Message - MOST RECOVER

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Differential Dx: Acute Stress Disorder

- Mental disorder due to a general medical condition
- Substance induced disorder
- Brief psychotic disorder
- Major depressive episode
- Posttraumatic stress disorder
- Adjustment disorder
- Malingering

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Treatment of Acute Stress Disorder

- No clear evidence that a particular intervention is helpful. "Watchful waiting" recommended by experts
- A few clinical trials underway
- "Debriefing" now demonstrated in clinical trials to be harmful to some under some circumstances

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DSM-IV Disorders

- Adjustment Disorder
- Acute Stress Disorder
- Posttraumatic Stress Disorder
- Dissociative Disorders

Slide 21

Posttraumatic Stress Disorder

(An anxiety disorder)

- Event:
  - Actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - Person responded with intense fear, helplessness or horror (disorganization or agitation in kids)
- Symptoms:
  - At least **1 Reexperiencing** symptom
  - At least **3 Avoidance** symptom
  - At least **2 Hyperarousal** symptom
- Distress or impairment
- Duration at least 4 weeks (Acute = less than 3 months; Chronic = 3 months or longer; Delayed onset = occurring at least 6 months post-event)

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Risk Factors for PTSD

- Degree and duration of traumatic exposure
- Biological factors
- Family and genetic vulnerability
- Previous exposure; experiential factors
- Preexisting psychiatric conditions
- Social supports

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High Risk Individuals

- Rape victims
- Assault victims
- Accident victims
- Traumatized children
- Victims with greatest exposure
- Victims of man made disasters
- Victims in developing countries

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Posttraumatic Stress Disorder

(Natural History)

- 7% of the general population per year are exposed to extreme trauma as defined by DSM-IV
- Roughly a third of people experiencing traumatic events develop Acute Stress Disorder
- Roughly a third of those ASD people progress to PTSD
- Prevalence in at risk populations 14 to 75%

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Groups at risk for PTSD

- Those very exposed
- Children
- Single parents
- Injured
- Bereaved
- Poor people
- Medically and psychiatrically ill
- Rescue & recovery workers
- Medical personnel
- Leaders
- Media workers
- “Hero” & “villain”
- Persons deemed responsible

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Differential Dx: Posttraumatic Stress Disorder

- Mental disorder due to a general medical condition
- Substance induced disorder
- Acute stress disorder
- Adjustment disorder
- Mood disorder (with or without psychotic fx)
- Schizophrenia or other psychotic disorder
- Obsessive-compulsive disorder
- Panic disorder; other anxiety disorders
- Malingering

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Managment of Posttraumatic Stress Disorder

- Primary prevention
- Secondary prevention
- Tertiary prevention

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Primary Prevention

- Minimize exposure to trauma (e.g., adequate emergency services, capacity to restore community services , life supports, access to financial recovery, limit exposure to certain risks, etc.)
- Prevent secondary injury
  - Provide respite and support--get person to safe environment
  - Facilitate continuity of old and access to new social supports
- Treat co-morbid disorders (medical and psychiatric)
- Treat ASD (?); stress debriefing (?); ß-blockers; SSRIs (?)

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Secondary and Tertiary Prevention

- Provide treatment
  - Cognitive-behavioral, exposure, pharmacological
  - Group, family, & couples
  - Inpatient treatment (therapeutic community)
  - *Eye movement desensitization (*EMDR) (Pt. recalls painful traumatic memory while attending to rapidly altering left/right visual or auditory stimulation) ?
  - Catharsis & standard psychotherapy of doubtful value
- Treat and manage co-morbid psychiatric disorders, including alcohol & substance abuse
- Facilitate social support availability, support groups
- Social and medical services

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Pharmacotherapy

(some with proven efficacy, othes not)

- Selective serotonin reuptake inhibitors (SSRIs)
- Tricyclic antidepressants
- Anticonvulsants and other mood stabilizers (CBZ, VPA, topiramate, lamotrigine, neurontin, Li^{+})
- Monoamine oxidase inhibitors (MAOIs)
- Beta-blockers (propranolol)
- Alpha-1-antagonists (prazosin); alpha-2-agonists (clonidine)
- Benzodiazepines
- Narcotic antagonists

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Psychotherapy

(some with proven efficacy, othes not)

- Cognitive Behavioral: seems to work best for those with more avoidance symptoms (and with guilt).
- Exposure therapies: seem to work best for those with lots of intrusion and hyperarousal symptoms.

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DSM-IV Disorders

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Depersonalization Disorder

Dissociative Amnesia

Dissociative Fugue

Dissociative Identity Disorder

Dissociative Disorder Not Otherwise Specified

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Depersonalization

(the phenomenon)

Feelings of detachment or estrangement from self. Feeling like an automaton or as if living in a dream or movie. A sensation of being outside of one's own mental processes, one's body, or parts of one's body. Often includes sensory anesthesia, lack of affective response, a sensation of lacking control of one's actions including speech.

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Depersonalization (& Derealization) (the phenomena)

- Up to 50% of adults will, at some point in their lives, experience at least one episode of depersonalization symptoms, often as a response to a distressing event.
- May occur with intoxication of many kinds, certain medications, seizures, anxiety, sleep deprivation, head injury or other central nervous system pathology.

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Depersonalization Disorder

- Persistent or recurrent depersonalization
- Intact reality testing
- Distress or Impairment
- Not caused by other things

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Dissociation
(the phenomenon)

A term used in many different ways:

- Disconnection of emotion from memory of events
- Disconnection of sensation (including pain) from experience
- Amnestic experiences
- Depersonalization or derealization experiences
- Absorption phenomena

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Dissociation
(the phenomenon)

- Some dissoication is a normal phenomenon in pre-adolescents (especially girls). But there is normal versus pathological dissociation (it's not a continuum).
- Dissociative defenses can be reinforced, but it's not clear that true dissociative defenses can be "taught", though they can be imitated.
- They can also be ignored, but it's not clear that ignoring dissociative defenses makes them go away, though they may become less apparent.
- FACT: there has been and continues to be a lot of confusion about this issue, in part because of legal issues.
- Can be assessed using the Dissociative Experiences Scale

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Dissociative Amnesia

- One or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, “to extensive to be explained by ordinary forgetfulness.
- Not due to other things
- There is distress or dysfunction as a result

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Dissociative Fugue

- Sudden, unexpected travel away from home or workplace, with inability to recall one’s past
- Confusion about personal identity or assumption of a new identity
- Not due to other things
- There is distress or dysfunction as a result

Dissociative Identity Disorder

- The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- At least two or these identities or personality states recurrently take control of the person's behavior.
- Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- Not due to other things.